

evidence of a hemorrhage, we should operate immediately, but if the x-ray picture shows no evidence of a depressed fracture there is no need to decompress. If we wait, dehydrate the patient and do as little damage as possible, we do the best for him.

Dr. A. J. Mooney, Statesboro, Ga.—Of the types of intracranial injuries discussed by the essayist, *type I* will get well of itself. In *type II*, where there is hemorrhage from the middle meningeal artery, the case will require subtemporal decompression and ligation. *Type III*, where there is hemorrhage from the ear or nose with unconsciousness, with rising or high systolic pressure, sometimes will recover with a decompression operation, but more frequently the patient will die.

There is one type that we see frequently since the days of reckless driving of automobiles. An automobile wreck occurs and a man is brought into the hospital unconscious. Physical examination reveals nothing except that the pupils may be contracted or possibly dilated. There is no spasticity and no paralysis. There is stertorous breathing, the blood pressure is normal or slightly increased. If we take the temperature a few hours later, we find it 102 or 102.5° F. The spinal fluid is bloody, and the x-ray may or may not show skull fracture. This type of case has an extremely high mortality, no matter what we do. Before death the temperature may reach 106 to 108° F., and I have seen it reach 108.2°. The condition there we do not know. I believe it is in some instances a cerebritis from the destruction of brain tissue due to the jar. Very often we find an abrasion on the side of the head and the injury is frequently associated with bleeding from the nose or ear. The infection gets into the brain tissue at the base of the brain, and the man dies from cerebritis or meningitis.

Dr. W. W. Harper, Selma, Ala.—I wish to ask two questions: first, will lumbar puncture drain an epidural hemorrhage? Second, why is lumbar puncture more dangerous in this condition than in spinal meningitis of the tuberculous type, or meningitis of the serous type, where there is an enormous accumulation of fluid?

Dr. J. E. Rawls, Suffolk, Va.—Our compound fractures have always given us better results than the simple fractures. This has been, so far as I know, the experience of others, as their statistics will show. It seems that a compound fracture acts as a therapeutic agent in decompressing the injured intracranial structures. On several occasions, when I have had a simple fracture with hematoma, especially around the occipital region, I have immediately converted it into a compound fracture by making a free incision through to the bone. The coma and other symptoms of intracranial pressure have often lessened and marked improvement has been evidenced. This is a remedy which should be thought of in this class of injuries.

Every injury of the head should be marked "Handle With Care." I have seen two patients whose death the orderly in the hospital hastened by handling their injured heads roughly in attempting to shave the scalp for surgical treatment.

Dr. Maes (closing).—My paper deals only with emergency surgery for the relief of cranial injuries, and does not attempt to outline the special measures employed by specialists who deal exclusively with these conditions.

INTRACRANIAL HEMORRHAGE IN THE NEW-BORN*

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Elizabeth Griffin, of Yazoo City, Mississippi, was referred by Dr. J. D. Darrington, Yazoo City, on September 9, 1926. The family history was negative.

Elizabeth was six days of age. She had been normally delivered and breast-fed. She began to nurse the second day, was apparently comfortable and healthy. Her bowels moved daily and urination was normal.

At 8 o'clock on the morning of the sixth day she refused nourishment. She became listless, pale, and by 7 o'clock in the evening had ecchymotic spots over her body. She was vomiting and gave the impression of a profoundly ill baby.

Examination at 7 p. m. showed a sick baby, with skin of a pale bluish tint. The eyes were sunken, temperature was 101°, throat normal, and heart action normal except for marked rapidity. There was no evidence of enlarged thymus. Blood hemoglobin was 110 per cent, and coagulation time prolonged to 25 minutes. Spinal puncture showed bloody serum. The Wassermann was negative.

The diagnosis was intracranial and visceral hemorrhage.

Mother's milk was given with a medicine dropper every two hours, and 20 c.c. of mother's blood was injected into the tissues. This was repeated in four hours, using 30 c.c. Spinal puncture was made and 15 c.c. of bloody serum were withdrawn. She died at 1 o'clock the following morning.

Of approximately 200,000 infants who died last year during the first year of life, 60,000 died the first week and 25,000 the second week. It is estimated that 50 per cent of these cases died from intracranial and visceral hemorrhage. The conditions causing this high death rate, whether post or ante-natal, should be closely studied in order that this appalling loss of life may be averted. Aside from the loss of life, the unnumbered cases of idiocy, epilepsy and paralysis that follow as direct and remote complications deserve our most serious consideration.

The blood coagulation time, or bleeding time, and the calcium estimation of the blood taken for both mother and infant before and after delivery might be of value. The objection to this is, however, that until the emergency arises it seems to be a needless procedure, and after the symptoms are well developed one rarely has time to go into the laboratory side of the question as fully as is desirable. The evidence points to some toxic condition which develops in the baby's blood after birth, and is not due

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to a pathological condition of the mother's blood. This is borne out by the fact that the usual treatment is injection of whole mother's blood, and that would hardly be beneficial if it were in any way responsible for the hemorrhagic state.

Syphilis is not apparently associated in any particular way as a causative factor. Hemorrhage probably is due to some toxic condition arising in the liver.

DISCUSSION (Abstract)

Dr. Oliver W. Hill, Knoxville, Tenn.—In many cases we can relieve the hemorrhage. The results of doing a spinal puncture and injecting some of the father's or mother's blood to increase the clotting time are often good. Immediate, heroic treatment is needed to save the child's life, or prevent permanent mental or physical injury. We should not wait to observe a while, but should make the puncture to relieve the pressure and drain off the fluid and save the child as much injury as possible.

A REVIEW OF THE FUNCTIONAL DISORDERS OF THE STOMACH*

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Functional disorders of the stomach are of much greater importance than the infrequent discussion at medical meetings would seem to indicate. It is a common experience that of the many chronic sufferers seeking medical aid for the relief of their digestive disturbances a large number have no discoverable pathological condition underlying their symptoms. These patients present the various sides and clinical pictures of functional digestive breakdown occurring in certain classes and types of individuals. Our interest in them should be manifested not only because of the frequency of occurrence, but also because a careful study of functional digestive disorders leads us into a most interesting and at times difficult field of differential diagnosis. As Fenwick¹ has said, "the science of gastric diagnosis is the art of taking trouble; it is at all times diametrically opposed to guesswork, and an accurate recognition of the nature of a complaint is the only possible basis for curative treatment."

It is very significant that one generation ago considerable space was given to the discussion

of functional disorders of digestion, but in recent standard works the number of pages devoted to such conditions has steadily diminished. This bears out the opinion expressed by Brinton,² in 1858, that the classification of the dyspepsias, then very extensive, would be further limited each year with a better understanding of the nature of the various types of digestive disorders included under the term gastric neuroses. The trend of modern medicine is toward a sharper limitation of the so-called neuroses, or functional disorders, regardless of the organ under consideration. With a broadening of our knowledge of the normal as well as the abnormal processes, and with the improvements in the methods of observation and investigation we find a definite narrowing of the general class of symptom-complex designated neuroses. Many writers would discredit the identity of functional disorders of the stomach, while others feel that "neurosis" is a charitable term used to shield one's ignorance of the real nature of the disturbance, or a sort of diagnostic label to be applied until the real cause can be revealed either by the process of time, or by further investigation. No doubt some of the conditions now regarded as primarily functional disorders of the stomach may in time disclose their organic nature, although we will probably always be justified in considering a certain number of gastric disturbances as functional in nature. It is a recognized fact that abnormal functional behavior may arise without structural changes, and that the very nature of a neurosis is so elusive and variable that it may simulate organic disease.

FREQUENCY OF THE DYSPEPSIAS

A review of a large series of cases of similar nature is always profitable, especially in showing the relative frequency with which such conditions may be encountered. Blackford,³ in an interesting summary of one thousand cases having gastric symptoms, found that 14 per cent had organic diseases of the stomach; 34 per cent presented extra-gastric diseases with reflex gastric symptoms; 18 per cent were due to systemic conditions, and 25 per cent had no discoverable pathological condition to account for their symptoms and were therefore designated functional disorders. A few years later Blackford and Dwyer⁴ in a survey of sixteen hundred and fifty digestive cases found that the relative frequency of abdominal diseases causing dyspepsia was: gastric ulcer, 1 per cent; gastric carcinoma, 2 per cent; reflex appendicitis, 4 per cent; duodenal

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